

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155229	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/27/2013
NAME OF PROVIDER OR SUPPLIER WOODLANDS THE			STREET ADDRESS, CITY, STATE, ZIP CODE 3820 W JACKSON ST MUNCIE, IN 47304		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>This visit was for the Investigation of Complaint Number IN00140067.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/12/2013. This survey included the Post Survey Revisit (PSR) to the investigation of Complaint Number IN00138594.</p> <p>Complaint Number IN00140067- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey date : December 27, 2013</p> <p>Facility Number : 000134 Provider Number : 155229 AIM Number : 10027540</p> <p>Survey Team : Kim Davis, RN, TC Debora Barth, RN Karen Koeberlein, RN</p> <p>Census bed type: SNF/NF : 72 Total : 72</p> <p>Census payor type: Medicare : 10 Medicaid : 53 Other : 9 Total : 72</p> <p>Sample : 3</p> <p>The Woodlands was found to be in compliance</p>	F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaint Number IN000140067.	F 000			